EXHIBIT 26

U.S. Department of Justice

Federal Bureau of Prisons

Federal Medical Center, Devens

P.O. Box 880
Ayer, MA 01432

EXHIBIT
MDF 8.24.05

January 23, 2003

Colleen O'Donnell
Inmate Systems Officer
56 Chester Street
Malden, MA 02148

Dear Colleen:

This is in response to your request for advanced sick leave. After reviewing your request, and the psychiatry staff review of the documentation you presented, I have recommended, and the Warden agrees, you will be granted 24 hours of advanced sick leave. This is to allow you sufficient time to obtain the requested medical documentation.

The medical documentation, you submitted does not provide sufficient information to support any facts alleged in the letter from George Milowe, M.D., stating you are totally disabled and the conclusion that your total disability is completely reversible based on environmental factors.

If you wish the Warden to re-consider your request for additional advanced sick leave the following information must be provided on your physician's letterhead and signed by your physician:

- an assessment of your current clinical status
- an estimate of the expected date of full or partial recovery

In addition you are required to submit a Standard Form 71 - Application for Leave, you must indicate the number of hours you are requesting, not to exceed 216 hours. This documentation must be received by January 31, 2003, or you will be placed on AWOL status beginning February 3, 2003.

Sincerely,

ISm

Stephen Gagnon
Inmate Systems Manager

REQUE. . FOR LEAVE OR APPROVE. ABSENCE

1. NAME *(Last, First, Middle Initial)*	2. EMPLOYEE OR SOCIAL SECURITY NUMBER

3. ORGANIZATION DOJ BOP

4. TYPE OF LEAVE/ABSENCE *(Check appropriate box(es) below.)*	DATE From:	DATE To:	TIME From:	TIME To:	TOTAL HOURS
☐ Accrued Annual Leave					
☐ Restored Annual Leave					
☐ Advance Annual Leave					
☐ Accrued Sick Leave					
☐ Advance Sick Leave					
Purpose: ☐ Medical/dental/optical examination of requesting employee ☐ Other ☐ Care of family member/bereavement, including medical/dental/optical examination of family member\					
Compensatory Time Off					
Other Paid Absence					
☐ Leave Without Pay					

5. FAMILY AND MEDICAL LEAVE

If annual leave, sick leave, or leave without pay will be used under the Family and Medical Leave Act of 1993, please provide the following information:

☐ **I hereby invoke my entitlement to Family and Medical Leave for:**

- ☐ Birth/Adoption/Foster Care
- ☐ Serious Health Condition of Spouse, Son, Daughter, or Parent
- ☐ Serious Health Condition of Self

Contact your supervisor and/or your personnel office to obtain additional information about your entitlements and responsibilities under the Family and Medical Leave Act of 1993.

6. REMARKS: .

7. CERTIFICATION: I hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing agency's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of information on this form may be grounds for disciplinary action, including removal.

EMPLOYEE SIGNATURE DATE

8. OFFICIAL ACTION ON REQUEST: ☐ APPROVED ☐ DISAPPROVED

(If disapproved, give reason. If annual leave, initiate action to reschedule.)

SIGNATURE DATE

PRIVACY ACT STATEMENT

Section 6311 of title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or to the General Services Administration in connection with its responsibilities for records management.

Where the employee identification number is your Social Security Number, collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this request.

If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

U.S. OFFICE OF PERSONNEL MANAGEMENT
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STANDARD FORM 71 (Rev. 12-97)
PREVIOUS EDITION MAY BE USED